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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED DEC 22 1943 318

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1002

Registrar's No. 10799

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days  
(Specify whether)  
 In this community 30 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
 (c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2825 Lawton  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Matthew Williams

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 148888

4. Sex Male 5. Color Col 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Amanda Williams 6. (c) Age of husband or wife if alive 55 years  
 7. Birth date of deceased May 10 1887  
(Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 25  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Unknown  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Amanda Williams

(b) Address 2825 Lawton ave

17. (a) Burial (b) Date thereof Dec 9 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood cem

18. (a) Signature of funeral director F. A. Green

(b) Address 2915 Franklin ave

19. (a) DEC 8 1943 (b) O. F. Meech  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5, year 1943 hour \_\_\_\_\_ minute 05 A. M.

21. I hereby certify that I attended the deceased from November 29, 1943, to December 5, 1943, that I last saw him alive on December 5, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death:  
Bronchopneumonia (autopsy)  
Cardiac Hypertrophy

Duration Terminal  
 Unk.

Due to \_\_\_\_\_

Due to 95

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature S. E. Smith (M. D. number) \_\_\_\_\_

Address 2601 Webster Date signed 12/6/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*J. A. Green*

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin Ave*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**